

Standard Insurance Company Enrollment Change Form

Mark all boxes and complete all sections that apply.
Return completed form to your Human Resources Department.

TO BE COMPLETED BY EMPLOYEE:

Employee Name (Last, First, Middle)	Group Name City of Green Bay	Group Number(s) 642796	
Your Address	City	State	Zip
Your Social Security #	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Job Title/Occupation

TYPE OF INSURANCE – Please check type of insurance that you are electing.

Check with your Human Resources Department about coverage options available to you and Evidence of Insurability requirements.

Employee Life Insurance (100% paid for by the City of Green Bay)

☐ Life with AD&D Employer Paid

Additional/Optional Life Insurance for Employee

☐ Additional/Optional Life with AD&D - \$20,000

Spouse and/or Child(ren)'s Optional Life Insurance –

Monthly premium is the same no matter how many dependent(s) you have enrolled.

☐ Spouse Guaranteed Amount - \$20,000 ☐ Apply for Additional \$30,000 through Underwriting –See Attached

Spouse Name: _____ Date of Birth: _____

(Attached Evidence of Insurability form must be filled out by spouse if applying for the additional \$30,000 of life insurance).

☐ Child(ren) Guaranteed Amount - \$10,000 (only eligible up to age 19)

Child(ren) Name: _____

Please Note: The Employee is automatically the Beneficiary for your Spouse and/or Child(ren), so dependent(s) do not need to name a Beneficiary. The Below Beneficiary information is for the employee to list who they would like as Beneficiary for their life insurance plan(s) they are currently enrolled in.

EMPLOYEE BENEFICIARY INFORMATION

This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated and delivered to the Employer during your lifetime. See page 2 for further information.

Primary – Full Name	Address	Soc. Sec. #	Relationship	% of Benefit
Secondary – Full Name	Address	Soc. Sec. #	Relationship	% of Benefit

CHANGE – Use only when you want to make a change after insurance becomes effective. Complete all boxes & sections that apply.

☐ Add Dependent ☐ Delete Dependent ☐ Name Change ☐ Beneficiary Change

Date of add/delete: _____ Former Name: _____ Other: _____

SIGNATURE

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required

Date (Month/Day/Year)